STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 89079-001**

v

Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
This 9th day of September 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On April 9, 2008, XXXXX, authorized representative of XXXXX., (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on April 16, 2008.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on April 24, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM Community Blue Group Benefits Certificate (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On November 11, 2007, the Petitioner had a serious accident and four of his upper teeth were knocked out. He was rushed to XXXXX where he received emergency care and treatment. Since there were no oral surgeons available, his wife drove him that same day to XXXXX where Dr. XXXXX, a nonparticipating oral surgeon, performed needed dental services. The amount charged for this care was $2,048.00. BCBSM initially paid $281.89 for these services.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on February 22, 2008, and issued a final adverse determination dated April 1, 2008.

III
ISSUE

Is BCBSM required to pay an additional amount for the dental services provided to the Petitioner by Dr.XXXXX?

IV
ANALYSIS

Petitioner's Argument

The Petitioner recognizes that the oral surgeon that provided his care has not contracted with BCBSM to provide services. However, since the Petitioner's care was needed as the result of an accidental injury and was provided on an emergent basis, he believes that BCBSM is required to pay significantly more for Dr. XXXXX services on November 11, 2007.

BCBSM's Argument

BCBSM says it initially paid $281.89 for the treatment resulting from the injury to the Petitioner for teeth.

However, BCBSM has reconsidered its position and has agreed to pay an additional $369.97. BCBSM says this additional payment will be sent to the Petitioner shortly. When this payment is made, BCBSM believes that it will have correctly paid for the services the Petitioner received from a nonparticipating provider.

Section 4 of the certificate, *Coverage for Physician and Other Professional Services,* explains how BCBSM pays nonparticipating providers. It says that BCBSM pays its "approved amount" for physician and other professional services – the certificate does not guarantee that charges will be paid in full. In addition, since the oral surgeon in this case does not participate with BCBSM, he is not required to accept BCBSM's approved amount as payment in full.

The certificate also indicates that multiple surgeries performed on the same day by the same surgeon are paid according to national standards recognized by BCBSM, where BCBSM pays the full approved amount for the primary procedure and one-half the approved amount for any secondary procedure.

The amounts charged by Dr. XXXXX and the amounts BCBSM has already agreed to pay for the November 11, 2007, care are shown here:

Procedure (CPT Code)	Amount Charged	Maximum Payment Level	BCBSM's Approved Amount	Amount Paid by BCBSM
21142	$330.00	$1,689.88	$330.00	$330.00
99201	$70.00	$44.44	$0.00*	$0.00*
70300	$24.00	$20.97	$20.97	$20.97
70330	19.00	$20.97	$19.00	$19.00
21440	1,605.00	$563.78	$563.78	$281.89**
Totals	$2,048.00			$651.86

* The approved amount for the primary procedure includes payment for the evaluation and management service. BCBSM doesn't allow a separate payment for this secondary procedure code.

** Multiple surgeries performed on the same day by the same surgeon are paid according to national standards recognized by BCBSM. BCBSM pays 50 % of the approved amount for a secondary procedure. The primary procedure is PC 21142.

BCBSM's maximum payment level for each service is determined by a resource based relative value scale (RBRVS), a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service, is regularly reviewed to address the effects of changing technology, training, and medical practice, and is adjusted by geographic region.

BCBSM also waived the out-of-network sanctions since the services were the result of an accidental injury or medical emergency.

BCBSM contends that when it pays the additional amount of $369.97 to the Petitioner it will have paid the proper amount for his care and is not required to pay more.

Commissioner's Review

The certificate explains that BCBSM pays an "approved amount" for physician and other professional services. The approved amount is defined in the certificate as the "lower of the billed charge or [BCBSM's] maximum payment level for a covered service." Participating and panel providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full and may bill for the balance of the charges.

The certificate explains this (on pages 4.26 – 4.27):

> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. . . .
>
> **NOTE**: Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

BCBSM has paid or has agreed to pay for the Petitioner's surgery based on the national standard that pays 100% of the approved amount for the primary procedure and 50% of the approved amount for any secondary procedures performed on the same day by the same surgeon. However, the certificate does not define how the primary procedure is determined. In this case, BCBSM determined the primary procedure based on its maximum payment amount. Since the maximum payment amount for PC 21442 is more than the maximum payment amount for the other procedures, BCBSM decided it was primary.

However, the amount charged by the surgeon and BCBSM's approved amount is much greater for PC 21140. Therefore it seems clear in this case that PC 21440 should be the primary procedure and the Commissioner so finds. BCBSM is required to pay 100% of the approved amount for PC 21440 ($563.78) and 50% of the approved amount for PC 21142 ($165.00). This will result in an additional payment of $116.89 to the Petitioner. The correct payment is shown in this table:

Procedure (CPT Code)	Amount Charged	Maximum Payment Level	BCBSM's Approved Amount	Amount Paid by BCBSM
21142	$330.00	$1,689.88	$330.00	$165.00
99201	$70.00	$44.44	$0.00	$0.00
70300	$24.00	$20.97	$20.97	$20.97
70330	19.00	$20.97	$19.00	$19.00
21440	1,605.00	$563.78	$563.78	$563.78
Totals	$2,048.00			$768.75

It is unfortunate that the Petitioner could not or did not use a participating provider. Nevertheless, there is nothing in the terms and conditions of the Petitioner's certificate that requires BCBSM to pay more than its approved amount (or 50% of the approved amount for secondary procedures) to a nonparticipating provider, even if no participating provider was available or even if the care was for a medical emergency.

The Commissioner finds that BCBSM is required to pay an additional $486.86 to the Petitioner for the care to treat the injury to his teeth (the $369.97 BCBSM has already agreed to pay and an additional $116.89 it must pay because of the Commissioner's finding that BCBSM erred in its determination of the primary procedure).

ORDER

BCBSM's final adverse determination of January 25, 2008, is modified in part. BCBSM is required to pay an additional $486.86 for the Petitioner's care from Dr. XXXXX. BCBSM shall pay this amount within 60 days and shall provide proof of payment to the Commissioner within seven

days after payment is made.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.